DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
Ft Leavenworth, Kansas 66027-2332

MEDDAC Regulation
No. 702-1

Product Assurance

Continuous Quality Improvement/Provision Of Patient Care Plan

1. PURPOSE. To provide Munson Army Health Center (MAHC) leadership, senior staff, and department chiefs with a framework for planning, directing, coordinating and improving services. The planning and services provided by MAHC will be responsive to community and patient needs while complying with Health Affairs (HA), Department of Defense, and Army regulations to include Medical Command's (MEDCOM) Strategic Plan. Improvement of patient outcome provides the emphasis of all planning and service efforts. Areas identified by the Community Healthcare Council, annual Army Family Action Plan Symposium, Community-wide Information Exchange, Command College Survey and Army Community of Excellence as community needs and patient needs will be considered and/or included in our overall plan. It is applicable to all divisions, departments, services, teams, and units of MAHC. This includes the support areas that provide services that indirectly impact on the quality of the direct care provided to the patient.

2. REFERENCES. Required and related publications and prescribed and referenced forms are listed in appendix A.

3. EXPLANATION OF ABBREVIATIONS AND TERMS. Abbreviations and special terms used in this regulation are explained in the glossary.

4. RESPONSIBILITIES.

a. Commander will:

(1) Provide the framework for planning, directing, coordinating, providing, and improving health care services that are responsive to community and patient needs, and that improve patient health outcomes.

(2) Ensure that services are planned based on the population served, the mission of MAHC, and the identified patient care needs.

(3) Be the authority for ensuring that the ongoing Continuous Quality Improvement (CQI) process of Patient Care, Risk Management, Utilization Management and Credentials Review activities are integrated and coordinated to provide the base for a comprehensive CQI program.

(4) Serve as the chairman of the health center's Executive Committee that is charged with approving the activities necessary for ongoing health center operations. The health center Executive Committee will also serve as the coordinating council for the health centers CQI program. This group will ensure that CQI, Utilization Management, Risk Management, and privileging activities are coordinated and integrated.

(5) Establish a health center Quality Management and Utilization Management (QM/UM) Committee to evaluate the quality of health care provided throughout the health center. This committee will establish, implement, maintain, and evaluate the Quality Improvement (QI) program; assure that the CQI program utilizes quantifiable standards and criteria; analyze reports for opportunities to integrate and coordinate departmental service or committee efforts and for health center wide interventions; report outcomes of the QI program to the health center Executive Committee, and ensure that implementation of the Utilization Management plan to maximize the allocation and utilization of resources to continuously improve the quality of care and services. In addition to reviewing reports on health center wide activities, reviews will be conducted on an indicator measurement system that will be submitted and presented by the appropriate activity.

(6) Establish a Credentials Committee to review all practitioner credentials and recommend the granting, reduction or removal of clinical privileges, medical staff appointment status, approve/disapprove all privileging actions and ensure that credentials and provider activity files are maintained in accordance with appropriate regulations and policies.

(7) Ensure that a program for the impaired health care provider is developed in accordance with (IAW) Army Regulation (AR) 40-48, Nonphysician Health Care Providers.

(8) Establish a Risk Management Committee to review and evaluate potentially significant medical incidents in order to identify true incidents of substandard care, patterns and/or potential trends with medical legal implications. This committee will also look at improvement opportunities, which could serve to reduce risk to the patient, staff, and/or health center.

(9) Responsible for Sentinel Event (SE) activities and their oversight IAW MEDCOM's Sentinel Event Policy dated 3 May 2000 and references cited in paragraph 1 of that policy. Detailed information on this process may be found in MEDDAC Reg 40-46, Risk Management Plan.

(10) Establish a Continuous Quality Improvement Plan as outlined later in this regulation.

b. Deputy Commander for Administration will:

(1) Coordinate all administrative, logistic, and budget support to the clinical service determined to be needed through the needs assessment.

(2) Ensure the administrative staff fully participates in and supports the development of the seamless network of interconnected clinical departments and services that emphasize coordination and collaboration of the care they provide.

(3) Coordinate all administrative activities and report to the Health Center's QM/UM Committee on ongoing CQI activities of the Medical Department Activity's (MEDDAC) administrative and support staff.

(4) Provide input and guidance to the QM/UM Committee concerning administrative and support issues as required.

(5) Serve as chairperson of the Environment of Care (Safety) Committee and provide for liaison between this committee, the Risk Management Committee, and the Health

Center’s QM/UM Committee.

(6) Ensure that the interdisciplinary, health center wide medical records review function is planned, implemented, and reported to the Health Center’s QM/UM Committee utilizing the appropriate record review format.

(7) Provide guidance and leadership to the administrative and support staff and the QI activities to provide for continuous quality improvement in patient care services. Coordinate QI activities related to management and administrative services, medical record services, and plant technology and safety management.

c. Deputy Commander for Clinical Services (DCCS) will:

(1) Serve as the Chief of the Medical Staff. Orchestrate the provision of patient care services to the military community by ensuring that timely access to care, thorough evaluation of the patient’s condition, competent treatment by a professional and caring staff, and appropriate care coordination and patient education are provided. This is achieved through the development of a seamless network of interconnected clinical departments and services that emphasize cross-sectional coordination and collaboration of the care they provide.

(2) Implement the Commander’s guidance for the determination of a community healthcare needs assessment in order to thoroughly understand what patient care services are needed, and desired, by the patient population. Design services to fulfill those needs and ensure those services address the nine “Dimensions of Performance” which are: Divided into two categories: “Doing the right thing” which includes efficacy and appropriateness, and “Doing the right thing well” which includes availability, timeliness, effectiveness, continuity, safety, efficiency, and respect and caring. These dimensions are addressed as recommended by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO).

(3) Develop recommendations for the appropriate compliment of professional staff required to provide the

medical care identified. Recommend the medical equipment necessary to support the medical staff and ensure those elements are in coordination with the organization's mission and available budget.

(4) Serve as chairperson of the QM/UM committee.

(5) Serve as chairperson of the Risk Management Committee and Credentials Committee; and provide liaison among these committees to the Health Center's QM/UM Committee.

(6) Plan, implement, and supervise a risk management and credentials program.

(7) Provide leadership and training to the clinical departments and services in the implementation of all CQI programs.

(8) Ensure that the review of surgical and other invasive procedures, blood, blood product usage, drug usage, and pharmacy and therapeutics are monitored and evaluated on an ongoing basis and ensure that the conclusions, recommendations, and actions resulting from the review are both appropriate and communicated to the QM/UM committee.

(9) Serve as chairperson of the Standards Review Committee, formerly known as the Quality Management Board.

d. Deputy Commander for Nursing will:

(1) Have the overall responsibility for the facility's treatment plan for the provision of nursing care.

(2) In accordance with AR 40-6, Army Nurse Corp, paragraph 2-4, will serve as principal advisor to the Commander on policies, procedures, activities, and matters pertaining to or affecting nursing.

(3) Report conclusions, recommendations, actions, and evaluations of the indicator base measurement activities in the Department of Nursing.

(4) Provide input and guidance to the QM/UM Committee concerning nursing and support issues as required.

(5) Provide guidance and leadership to the nursing staff in QI activities to provide for continuous quality improvement throughout patient care services. Ensure that nursing activities are incorporated into Service and departmental CQI projects.

(6) Provide the stimulus and resources to permit participation by employees on QI teams.

(7) Ensure that all professional nursing personnel maintain proper licensure and certifications as required.

e. Departments and Services. The Chief will:

(1) Implement the policies and priorities of the Command regarding the provision of patient care services to the patient population.

(2) Integrate the department/service into the primary functions of the treatment facility by ensuring that all patients are provided treatment in a coordinated and collaborative manner with other departments and services.

(3) Retain accountability for all applicable professional, administrative, CQI, risk management, and, as required privileging and competency functions. Provide appropriate orientation, in-service training, and continuing education to all persons within the department/service.

(4) Develop in conjunction with the QM office, a policy which outlines the means by which each activity will use indicator management systems to assess and improve performance and participate in cross-functional activities to improve overall organizational performance.

(5) Determine the required qualifications and competence of department/service personnel and recommend the number of sufficiently qualified and competent personnel to provide care/service. Recommend the amount of space and other resources required to provide the treatment services adequately.

(6) Based on the guidelines established in this policy and the Joint Commission Comprehensive Accreditation Manual for Ambulatory Care, health center staff will develop, implement, and document a QI program to support the health center's QI program. This program will include the identification prioritization of indicators to be used in monitoring the important aspects of care. All QI teams will report their findings, studies, and accomplishments through the Standards Review Committee to the QM/UM Committee and the Executive Committee.

(7) Conduct departmental meetings or service meetings at least nine months per year or as needed to coordinate CQI. Department/Service will forward minutes of meetings to QM/UM on a monthly basis. Reports will be presented at QM/UM Committee meetings as outlined in the Calendar of QI Review and Evaluation reports (appendix B). The meetings will provide the forum for the sharing of information about area specific and health center

wide CQI activities with the staff. Reports will document activities related to include indicator measurement, risk management, utilization management, safety, infection control, invasive procedure review, blood usage, medical record review, drug usage evaluation, and pharmacy and therapeutics activities as appropriate for the respective department, service or team.

(8) Provide for documentation and communication of the findings, conclusions, recommendations, and actions taken as a result of data collected about the indicators and the follow up evaluation of the effectiveness of actions taken. Ensure the indicator based status reports are forwarded through appropriate organizational channels to the QM/UM Committee. These reports should not only have a problem focus but should reflect all tenets outlined in approving organization performances as outlined in this plan. See examples of QI forms in appendix C.

(9) Provide support for further development of multidisciplinary QI teams. Ensure that staff members are provided the opportunity to participate in orientation and education programs concerning CQI.

(10) Ensure the appropriate CQI information is

utilized and recommendations to the credentials committee for privileging and reprivileging actions as required.

(11) Conduct an annual analysis to include a review of organizational improvement. A summary report of this analysis will be forwarded to the QI office in the format prescribed by that office.

(12) Participate in the selection of sources of care or service outside the treatment facility that are not provided by the organization.

f. The Quality Improvement Coordinator/Risk Manager and staff will:

(1) Coordinate the development of a comprehensive MEDDAC CQI program that provides for the integration of QM, RM, and privileging activities. Provide input to utilization management as needed. Serve as consultant to the department leadership and staff in the development, implementation and evaluation of ongoing QM activities. Provide appropriate education/technical support to leadership and to administrative clinical and support staff at all levels.

(2) Collect, organize, and analyze data longitudinally by provider. This will allow for review of important single events by appropriate service, risk management and practice patterns or trends in patient care services.

(3) Develop systems for documenting and tracking the discussion, conclusions, recommendations, actions, and follow-up evaluation of actions that result from QM and RM activities.

(4) Coordinate the results of the external (Forensic Medical Advisory Service studies) peer review; MAHC Form 482-R, (Temporary form) Occurrence Screening Checklist, unusual occurrence, Department of the Army (DA) Form 4106, Quality Assurance/Risk Management Document; and report potential compensable events.

(5) Provide for the review and validation of credentials for the purpose of granting privileges and appointment status and reprivileging and reappointment as

outlined in AR 40-68, Quality Assurance Administration, applicable portions of AR 40-48, Nonphysician Health Care Providers, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

(6) Coordinate risk management functions to include reviewing all occurrence data in coordination with the Claims Judge Advocate, and facilitating the risk management committee meetings. Alert the health center Executive Committee of all adverse patient occurrences and potential compensable events.

(7) Responsible for notifying Commander of Serious Medical Incidents and/or potential SE. Will assist Commander in determining if an incident meets the definition of a SE. Will assist the Commander in designating a Sentinel Event Response Team (SERT) and begin the process of conducting a Root Cause Analysis (RCA) and Action Plan as needed.

(8) Maintain the confidentiality of QI and risk management records and reports.

g. Quality Improvement Teams:

(1) The Standards Review Committee will charter and monitor all QI teams. The Standards Review Committee will report to the QM/RM Committee at least quarterly, and more often if needed.

(2) The QI teams will generally be composed of 6-12 members who are the subject matter experts; a team leader, who directs the continuous improvement process; and a team facilitator who provides consultation for team processes. The leader and facilitator will receive formal training in Performance Improvement Plan (PIP), CQI principals and leadership when possible. Each team will be selected and chartered by the Standards Review Committee and empowered by the Executive Committee to apply their multidisciplinary knowledge to special problems/processes, and to be the agents for change within the MEDDAC. The teams investigate, formulate, and present recommendations, reflecting state of the art processes through the Standards Review Committee for command approval. The QI teams, under the direction of the Standards Review Committee will recommend select staff for training in PIP/CQI and provide mock surveys for assessing

MEDDAC adherence to JCAHO standards. The Executive Committee will act as an executive steering committee, which will oversee the health center's PIP/CQI program and take action on QI team recommendations. The health center's quality management facilitator will be the chief of QI.

(3) PAT - Process Action Teams are groups or teams whose purpose is to study or investigate a specific project or process. Teams are usually multidisciplinary, involving those who take part in the process being studied. Once the project is complete, the team will generate a final report for future tracking. Some teams will dissipate at this point, but others may need to stay in place to monitor long-range projects.

h. Other responsible individuals or elements:

(1) All MEDDAC staff will participate in CQI and risk management activities under guidance of the Chief of their respective areas. MEDDAC staff will be responsible for:

(a) Participating in the CQI process to include the following: delineating the scope of care and identifying important aspects of care (key function) related to services provided. Developing indicators using the indicator measurement system to facilitate outcome based management. Placing emphasis on improving organizational performance through planning, designing, measuring and assessing performance to improve the abilities of the organization.

(b) Participating in QI teams as members, team leaders, and/or facilitators.

(c) Being proactive in acquiring and maintaining licensure privileges, certifications and continuing education IAW their individual performance standards and requirements. It is the responsibility of the individual staff member to ensure that the MEDDAC has a current record of these activities.

(2) The Patient Representative Officer will plan, organize, implement and evaluate the patient advocacy program to include reporting to the QM/UM committee the discussion, conclusions, and recommendations for actions and/or follow-up resulting from the trending of patient satisfaction statistics and patient discharge survey data. This will include the

management enclosure of all management complaints.

(3) The Chief, Logistics Division, in conjunction with the Safety Officer, will ensure that the health center complies with all pertinent laws, policies, and regulations regarding the health center environment and infrastructure. All pertinent information concerning materials management is reported to the QM/UM or RM Committees as appropriate.

5. MAHC VISION, MISSION, VALUES, AND STRATEGIC GOALS.

a. The Vision, Mission, Values, and Strategic Goals are the foundation for the care we strive to provide and for our business practices. The eight core values are integrated into day-to-day relationships with all we serve or work with in partnerships. Business is conducted ethically, with integrity, honesty, and confidentiality.

b. The mission, values, standards of behavior, and guiding policies provide the framework for the ethical practices that MAHC demonstrates in the provision of patient care and business relationships with patients and the public. The guiding policies include but are not limited to all areas of patient and employee rights: billing, marketing, relationships with other health care providers, and education. The guiding policies provide the support in the promotion of patient care and patient preferences, including the decision to continue or discontinue treatment, recognizing the health center’s responsibilities under law; informing patients of their responsibilities in the care process; and managing the health center’s relationships with patients and the public in an ethical manner.

c. Each individual has a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. The core values provide the framework to meet each individual’s needs and preferences. Each patient care area within the organization follows standards of care based upon the needs of the patient and delivers the same level of care to each individual. The health center provides services to patients and their families when the services can be safely provided.

(1) The VISION of MAHC is to be the primary care facility of choice, staffed with a team of adaptable healthcare professionals, trained and ready to provide high quality, accessible, cost-effective medical care in an ever-changing environment.

(2) The MISSION of MAHC is to promote military readiness by providing high quality, cost-effective, accessible medical care and health promotion programs for active duty, retirees, their families, and the United States Disciplinary Barracks (USDB).

(3) MAHC VALUES:

(a) Absolute Patient Focus: We will be committed to providing exemplary health services to all entrusted to our care.

(b) Loyalty: Bear true faith and allegiance to the U.S. Constitution, the Army, MAHC, and other soldiers.

(c) Duty: Fulfill your obligations

(d) Respect: Treat people as they should be treated.

(e) Selfless-Service: Put the welfare of the nation, the Army, and your subordinates before your own.

(f) Honor: Live up to all the Army values.

(g) Integrity: Do what’s right, legally and morally.

(h) Personal Courage: Face fear, danger, or adversity (physical or moral).

(4) STRATEGIC GOALS. MAHC is dedicated to excellence in health care for its community. To that end, the organization as a whole will participate in systematic performance improvement efforts. These efforts will be part of every day activities for staff throughout the health center. Efforts will focus on the processes inherent in health care activities and will elicit multi-disciplinary

cooperation. Corporate goals have been defined in the strategic plan as follows:

(a) Readiness and Training

(b) Health Promotion and Disease Prevention

(c) Patient Care and Disease Management

(4) Better Business Practices

6. SCOPE OF PATIENT CARE, GENERAL DESCRIPTION. MAHC is a military health center that provides Same Day Surgery, Primary Care, and some Specialty Care. In addition to the main cluster of buildings where patient care is rendered, we have two outlying clinics. The Richards-Gebaur TRICARE Clinic located in Kansas City, Missouri and the clinic located within the USDB, Fort Leavenworth, Kansas. Ancillary services that are available include Radiology, Laboratory and Pharmacy. The Medical Staff is organized into Department of Medicine, Department of Primary Care, Department of Surgery, Preventive Medicine, Community Mental Health, Nutrition Care and Optometry. All members of the Medical Staff belong to one of the aforementioned departments based on their clinical specialty.

a. DEPARTMENT OF MEDICINE: The Department of Medicine is composed of Internal Medicine, Infectious Disease, Dermatology, Neurology and Clinical Pharmacology. Members of the Department of Medicine provide primary care services as well as management of complicated medical patients in an outpatient setting. Providers have been granted privileges at local civilian hospitals and have the ability to admit and treat patients according to their privileges. Clinical Areas include but are not limited to:

Allergy-Immunology	Infectious disease
Cardiology	Internal medicine
Dermatology	Nephrology
Endocrine and metabolic disease	Neurology

Gastroenterology	Oncology
Gynecology	Pulmonary disease
Hematology	Pheumatology

(1) The Medical Treatment Facility (MTF) has a Resource Sharing Agreement with a Neurologist who sees patients once a month at the MTF. In addition we have an arrangement through Great Plains Regional Medical Center/MEDCOM where we have visiting specialty medical consultants (i.e., Reserve Dermatologist, Infectious Disease) coming from other MTFs within the region.

(2) Diagnostic and therapeutic tests and procedures performed by these physicians include but are not limited to lumbar punctures, exercise treadmill testing, flexible sigmoidoscopies, paracentesis, and thoracentesis.

b. DEPARTMENT OF PRIMARY CARE: The Department of Primary Care is composed of the following services:

Family Practice	Physical Exam and Flight Medicine
USDB Health Clinic	
Richards-Gebaur TRICARE Clinic	Pediatrics

(1) Members of the Department of Primary Care diagnose and treat the normal range of adult and pediatric health problems in an outpatient clinical setting within the MTF. Practitioners generally manage the uncomplicated aspects of the following diseases and will consult subspecialties if appropriate:

Allergy-Immunology	Internal medicine
Cardiology	Nephrology
Dermatology	Neurology
Endocrine and metabolic diseases	Pulmonary disease
Gastroenterology	Rheumatology
Gynecology	Oncology
Hematology	Pediatrics
Infectious disease	

(2) Family Practitioners generally manage the following uncomplicated procedures:

(a) Minor surgical procedures such as repair of simple lacerations and Incision & Drainage (I&D) of soft tissue abscesses.

(b) Invasive diagnostic procedures such as excisional biopsy, sigmoidoscopy, vasectomy, and bone marrow aspiration.

(3) Family Practitioners, who have clinical privileges to do so, provide routine obstetrical care. Family Practitioners have clinical privileges at local civilian hospitals that enable them to admit and treat patients IAW privileges granted at individual hospitals.

(4) The USDB Health Clinic provides assessment, diagnosis and treatment for the physical problems of inmates at the USDB. Sick Call is held Monday through Friday starting at 0500. Scheduled appointments are seen Monday through Friday after sick call. A Family Practice Physician provides oversight for this general outpatient clinic. Optometry and Physical Therapy clinics are held routinely on site.

(5) The Richard-Gebaur TRICARE Clinic provides Primary Care Services and Physical Therapy Services Monday through Friday. A Family Practice Physician provides oversight for this clinic.

c. DEPARTMENT OF SURGERY: Ambulatory Surgery is available within the MTF. These cases are done on a same day basis as determined by the surgeon. If the surgeon determines prior to surgery that the post operative care will exceed 23-hours, then the procedure may be performed in a civilian hospital IAW privileges granted to our providers at these facilities. Operative patients specifically excluded for care at the MTF are patients with anticipated postoperative care for longer than 23-hours, poly-trauma, complex and/or severe multisystem disease requiring Intensive Care Unit (ICU) monitoring, telemetry monitoring, ventilatory support, monitoring of vital signs more than every four hours, invasive monitoring, or total care secondary to multiple, severe, disabilities.

(1) The Department of Surgery is composed of the following specialties:

Nurse Anesthesia	Orthopedic
General Surgery	Podiatry
Obstetrics/Gynecology	Physical Therapy

(a) The MTF has a Resource Sharing Agreement with a Podiatrist who sees patients once a week in the Orthopedic Clinic. Through contract Ears, Nose and Throat and Audiology support is provided once a month. In addition we have visiting specialty medical consultants coming from other MTFs within the region.

(b) Invasive procedures include, but are not limited to, the following:

Advanced laparoscopic surgery
Ankle, Knee, Shoulder Arthroscopy
ACL (Anterior Cruciate Ligament Repair)
Cholecystectomy
Dilatation & Curettage (D&C)
Hernia repair
Pediatric Surgery – (limited)
Tubal Ligation
Thyroidectomy/Parathyroidectomy
Esophagoduodenoscopy
Limited thoracic & thorascopic procedures
Mastectomy/Lumpectomy & axillary dissection
ORIF (Open Reduction or Internal Fixation of Fractures)
Appendectomy
Breast biopsy
Bunionectomy
Colonoscopy
Exploratory Laproscopy
Hemorrhoidectomy
Pediatric Dentistry

(c) All surgical procedures requiring general, spinal, other major regional anesthesia and sedation/analgesia medication are performed only in the Operating Rooms. Surgical procedures that require local anesthesia are performed in clinics with monitoring equipment and trained staff used for patient safety.

(d) Upper and lower gastrointestinal endoscopy are performed in the procedure room located in the Operating Room suite.

(e) Surgeons, dentists, and podiatrists who have been granted privileges through the credentialing processes described in the MAHC Staff Bylaws, Rules and Regulations, shall perform surgical procedures.

d. DEPARTMENT OF COMMUNITY MENTAL HEALTH: The Department of Community Mental Health is composed of three services. These include the Psychiatry/Psychology Service, Social Work Service, and the Alcohol and Drug Abuse Prevention Control Program. The three services work in a complimentary fashion

to accomplish the mission of the Community Mental Health Department.

e. DEPARTMENT OF PREVENTIVE MEDICINE: The Preventive Medicine Program consists of the following mutually supporting elements: Office of the Chief, Epidemiology and Disease Control, Environmental Health, Community Health Nursing, Occupational Health, and Industrial Hygiene.

f. LABORATORY: Clinical laboratory includes phlebotomy, hematology (with limited coagulation studies), microbiology, urinalysis, clinical chemistry, and serology. Most requested clinical tests not performed in the lab are sent to Brooke Army Medical Center (BAMC) or local Reference Lab. Additional laboratory support is available if required. Anatomical pathology includes all surgical specimens and PAP smears, and is currently sent to BAMC, San Antonio, Texas. On order, local pathology group may be used for emergent and frozen section specimens.

g. NUTRITION CARE: Includes services rendered to outpatients and the community. Services include nutrition risk screening, assessment, nutrition therapy, education plans/patient goals, weight control, diabetic education, cholesterol education, and prenatal classes.

h. OPTOMETRY: The following procedures are offered in the
clinic: visual examination, treatment of eye diseases, and referral to ophthalmologists.

i. RADIOLOGY: All services are provided by a board certified Radiologist or licensed technologists who supervise non-licensed technologists. Services and procedures offered by the Radiology Department include: mammography exams with the exception of stereotatic procedures, plain films, ultrasound, and fluoroscopic exams.

7. Continuous Quality Improvement/Performance Improvement Plan (CQIP/PIP). CQIP/PIP provides for ongoing planning, designing, measuring, assessing, and improving the direct and indirect processes which impact on the provision of quality patient care. This plan will provide for the integration of this ongoing process with Risk Management, Quality Management

(CQI and Indicator Measurement)/Utilization Management, and Credentials Review and Privileging. These components will form the basis for the health center's CQI plan. The intent of this plan is geared

toward continuous improvement resulting in better quality medicine, increased access by our patient population, and customer satisfaction with the services they have received. A summary of the cycle for improving performance follows:

a. Plan. Design/Redesign -- creating or modifying a process.

(1) Select the process/problem that will be addressed first (or next) and describe the improvement opportunity.

(2) Describe the current process surrounding the improvement opportunity.

(3) Describe all of the possible causes of the problem and agree on the root cause(s).

(4) Develop an effective and workable solution and action plan, including targets for improvement.

b. Do. Measure -- Implementing the solution or process change and monitoring the milestones and measures - collecting data about the performance and/or results of a process.

(1) Provides baseline data about how a process is performing.

(2) Helps staff determine when a process needs more attention.

(3) Demonstrates the effect of an improvement action.

c. Check. Assess -- Analyzing data before and after taking action to improve performance should be done to determine whether improvement occurred.

(1) Review and evaluate the result of the change.

(2) Confirm/establish the means of monitoring the solution, are measures valid?

(3) Is the solution having the intended effect? Any unintended consequences?

d. Act. Improve -- Reflecting and acting on learnings.

(1) Assess the results and problem-solving process and recommend changes.

(2) Continue the improvement process where needed; standardize where possible.

(3) Celebrate success.

8. CREDENTIALING HEALTH CARE PROVIDERS. This process will be conducted in accordance with AR 40-68, AR 40-48 and JCAHO standards. Specifically, a licensed, independent practitioner will apply through service and department chiefs for privileges he feels he is entitled to perform. Granting of privileges will be based on experience and documentation of competency, not just by a blanket specialty approval and only for those procedures that are performed/supported within MAHC. In addition privileges will be based on what the facility can support. The credentials coordinator in the QM office will accomplish verification of licensure, education, and ensure documentation of performance. This information will be transmitted confidentially to the appropriate service or department chief who will evaluate and make recommendations on the practitioner's application based on his experience, education, training, and capabilities. That information will then be submitted to the credentials committee. The credentials committee will then vote to recommend to the commander the approval, disapproval, or modification of all requests for privileging. MAHC will grant privileges only for those procedures that are performed within MAHC. Practitioners requesting privileges that are not performed at this facility will not have their privileges formally denied, but rather stated that a particular portion of their request is not applicable due to the mission/resources of this

organization. This committee shall meet on a monthly basis, however, with authorization by the DCCS, the credentials coordinator is authorized to perform a voting walk-through for any provider who may need to be credentialed before the scheduled credentials committee meeting. The DCCS shall vote only in cases where there is a tie in the number of votes for or against a practitioner requesting privileges.

9. COMPETENCY BASED ASSESSMENT. Assessment of competency will be initiated by the first line supervisor during the initial employment process for civilians and during the initial

inprocessing process for military personnel. New employees will attend a mandatory health center orientation given by the Munson Education, Readiness, and Training division and a unit level orientation given by their immediate supervisor. Additionally, employees will attend mandatory annual training during the employee’s birth month. Competency will be assessed by observation of job performance, skill verification checklists, or written tests. Competency, to include age-specific competencies where applicable, will be assessed under the following conditions: upon initial employment, when new equipment or technology is introduced into the units or as need arises. Employees may receive quarterly counseling or annual reviews, which may serve as written documentation of their competency. Orientation specific to worksite will be the responsibility of the supervisor. Contract employees will also receive mandatory health center orientation and mandatory annual training during their birth months. Orientation specific to worksite will be the responsibility of the contractor.

10. RISK MANAGEMENT (RM) OFFICE. The review and analysis of all atypical or unfavorable incidents is essential for this MEDDAC. The purpose of this process is to protect this organization, establish a nonpunitive learning environment for all health care staff, and create a climate for improvement. Everyone in the health center will participate in risk management. The formal RM Committee is a multi-disciplinary organization consisting of health center staff as prescribed by MEDDAC Reg 15, MEDDAC Committee Structure. This committee will evaluate all unusual or untoward events occurring within this MEDDAC's area of responsibility in accordance with AR 40-

68 and MEDDAC Reg 40-46. The Risk Management Committee will effect improvements within their scope and address problems beyond their scope to the Executive Committee. All reporting, formatting and structuring will be done IAW AR 40-68. In addition will be responsible for coordination of SERT and RCA in accordance with Memorandum for Commanders, MEDCOM Regional Medical Centers/MEDCENs/MEDDACs, Subject: Sentinel Event (SE) Policy dated 28 May 2000 and current AR 40-68.

11. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT (QM/UM). The QM/UM Committee is a multi-disciplinary committee made up of the clinical department chiefs and administrative department chiefs whose purpose is to review the quality and cost-effectiveness of medical care provided in this facility. This committee serves as a CAPSTONE Committee for the review of committee minutes identified in MEDDAC Reg 15. The committee will review all

patient care evaluation and management review activities, and identify problems for follow-up action and resolution. This committee will strive to ensure the appropriate allocation of resources resulting in the provision of the best quality care possible in the most cost-effective manner possible. Review will include utilization of all resources (i.e., short term observation use, clinical paths, outpatient service, human, financial, supplies, equipment, and space), which provide for the provision of health care to the beneficiaries of MAHC. All department chiefs are responsible for reviewing and analyzing the quality of services provided and use of the resources allocated to their departments, ensuring the proper utilization of these resources. They will report discrepancies in resource allocation (under resourced, over resourced) and any quality issues to the QM/UM Committee. The QM/UM Committee will effect changes within their scope and will address problems beyond their scope to the Executive Committee. Any resource allocation problem adversely affecting quality of care will be addressed at this committee.

12. INDICATORS MEASUREMENT SYSTEM. This is the utilization of institutional data sources as a basis for understanding the MEDDAC's care outcomes, structures, and processes, with the intent of implementing steps from improvement and testing improvements. These indicators include, but are not limited to, surgical and other invasive procedure reviews, drug usage

evaluation, medical record reviews, blood usage review, infection control, and safety. These indicators will be measured and assessed through the following mechanisms:

a. The indicators to be evaluated will be identified through the various department chiefs, as well as chairpersons of the QI teams, documented and reported to the QI committee.

b. Indicators will be reviewed on a monthly basis or as needed at the departmental level and reported to the QM/UM committee.

c. Multi-disciplinary indicators and teams are used when specific issues are identified for intensive assessment and improvement, or to assist in the design of new processes.

d. Performance improvement information is used to educate all healthcare team members.

e. The performance improvement information is also referenced in employee evaluation and Health Care Providers recredentialing/reappointment procedures.

f. Indicator data will be used in measuring and assessing performance systems and developing ways to improve or maintain the program.

g. As previously mentioned, this will be a continuous process with no set beginning and no set end.

13. SURGICAL AND OTHER INVASIVE PROCEDURE REVIEW. All surgical
and endoscopic procedures are reviewed. Indicators are usually determined by the high risk, high volume and problem prone areas. Selected information, unique to the department, is collected and analyzed on an ongoing basis. The results of the review and evaluation of this information are presented and discussed at departmental meetings and presented at the QM/UM Committee. See the Department of Surgery QI Plan, paragraph 9.d.(1)-(7) for a more detailed description.

14. BLOOD USAGE EVALUATION. As of 1 September 2000 blood and

blood products are not stored on site at MAHC. We have a Memorandum of Understanding with Veteran's Administration Medical Center to provide all blood and blood products. The, Chief, Laboratory Service, will monitor and trend the usage of blood and blood products, and report the analysis of this data collection with appropriate conclusions, recommendations, and proposed actions to the Health Center Risk Management Committee on at least a quarterly basis.

15. RADIOLOGY REVIEW. Privileged radiologists perform invasive and noninvasive procedures using ionizing radiation or ultrasound. Some procedures may require the use of contrast (oral, rectal, or intravenous). Radiologists will review all invasive procedures upon completion of the study. A peer review of 15-20 percent of a monthly workload will be conducted on a quarterly basis.

16. DRUG USAGE REVIEW. Chief, Pharmacy Service in conjunction with the Pharmacy and Therapeutics Committee will coordinate the health center wide pharmacy and therapeutics activities. PAT teams may be utilized as needed to accomplish drug usage review. It will be the responsibility of this committee to coordinate the selection, prioritization and criteria development for the evaluation for drug usage. The Pharmacy and Therapeutics

Committee will report conclusions and improvement recommendations, actions and/or follow-up to the QM/UM Committee at least quarterly. The results of drug usage evaluations will be reported to the QM/UM Committee at least quarterly.

17. MEDICAL RECORDS REVIEW. The Chief, Patient Administration Division, will ensure that an interdisciplinary medical record review committee completes medical record review. This committee will review ambulatory patient visit and outpatient medical records for completeness and pertinence and report findings, conclusions, improvement recommendations and actions to the QM/UM Committee on at least a quarterly basis or more often as needed.

18. INFECTION CONTROL. The Infection Control Officer, in conjunction with the Infection Control Committee, will be responsible for planning, organizing, coordinating and evaluation of the health center wide infection control

functions and ensuring that pertinent information is communicated to the QM/UM Committee. This will be done on at least a quarterly basis.

19. SAFETY. The Safety Officer, in conjunction with the Environment of Care Committee, will plan, organize, coordinate, and evaluate all health care wide safety functions and ensure that pertinent safety information is communicated to the QM/UM Committee on a quarterly basis. Pertinent information will include, but not be limited to, review and trends related to accidents, injuries, patient and employee safety and other safety issues.

20. EDUCATION AND TRAINING. The implementation of a CQI/PIP will require extensive, ongoing education and training for all personnel. These educational programs will be planned and developed by QM and Munson Education, Readiness, and Training offices. The objective will be to provide all health center personnel with education and/or training opportunities. This will be an ongoing, continuous process. The educational plan and program content will be published in informal memorandums, which will be forwarded to all personnel as required.

21. RECORDING AND REPORTING. Documentation of CQI/PI activities will be completed as follows:

a. Departments will document CQI/PI activities in the minutes of the department meetings. Department chiefs may require subordinate services to also document CQI/PI activities.

Format will be as per guidance given by the QM office (sample format at appendix D). The departments will utilize the indicator measurement system to document and report their CQI activities (see MAHC 587-R, Summary of QI Indicator). These reports will be chronological and will be used to record the discussions, conclusions, recommendations and/or actions about the data collected for the indicator.

b. Reports by department will be outlined in this plan in the previous sections. If not specifically mentioned, the reports will be submitted monthly to the QM/UM committees.

22. CONFIDENTIALITY AND DISCLOSURE.

a. All activities related to CQI will be covered by the provisions of Title 10 United States Code (USC), Section 1102(B).

b. All CQI documents will be labeled as follows: Confidential QI records, disclosure prohibited under Title 10 USC, Section 1102(B), unauthorized disclosure carries a $3,000 fine.

c. The commander has the sole authority to authorize release of records of CQI activities under the provisions outlined in AR 40-68.

23. POTENTIAL QUALITY ISSUES FOR CONTRACTED CARE OUTSIDE MTF. See appendix E, Memorandum dated 12 April 2000 with description and copies of flowcharts describing the processes in place with contractor for addressing these issues.

24. PROGRAM APPRAISAL. All involved areas will appraise the effectiveness of the CQI/PIP Plan during January of each year. The appraisal process will provide the opportunity to reassess the priorities based on important aspects of care and indicators by the departments, services and teams. Each department will be required to provide information on how patient care was improved through the CQI Plan.

The proponent for this regulation is the Clinical Operations Division. Users are invited to send comments and suggested improvements on DA Form 2028, Recommended Changes to Publications and Forms, directly to the Commander, USA MEDDAC, ATTN: MCXN-COD, Ft Leavenworth, Kansas 66027-2332.

(MXCN-COD)

FOR THE COMMANDER:

OFFICIAL

RICHARD W. SALGUEIRO
MAJ, MS
Deputy Commander for

Administration

JEREMY T. MELLER
CPT, MS
C, Information Management
Division

DISTRIBUTION:
A

MEDDAC Reg 702-1

Appendix A

References

Section I
Required Publications

AR 40-6
Army Nurse Corp (cited in para 4.d.(2))

AR 40-48 (cited in para 4.a.(7); f.(5); 8.)
Nonphysician Health Care Providers

AR 40-68 (cited in para 4.f.(5); 8.; 10.; 22.c.)
Quality Assurance Administration

MEDCOM Sentinel Event Policy (cited in para 4.a.(9); 10.)

MEDDAC Reg 15 (cited in para 10. and 11.)
MEDDAC Committee Structure

MEDDAC Reg 40-46 (cited in para 4.a.(9); 10)
Risk Management Plan

Title 10 USC, Section 1102(B) (cited in para 22.a. and b.)

Joint Commission on Accreditation of Healthcare Organizations
Comprehensive Accreditation Manual for Ambulatory Care
(cited in para 4.f.(5); 8.)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards (cited in para 4.f.(5); 8.)

Department of Surgery QI Plan (cited in para 13.)

Section II
Related Publications

AR 25-50
Preparing and Managing Correspondence

AR 40-66
Medical Record Administration

MEDDAC Reg 702-1

MEDDAC Reg 40-50
Medical Staff Professional Rules and Regulations

Section III
Prescribed Forms

MAHC Form 482-R
Occurrence Screening Checklist

MAHC Form 587-R
Summary of QI Indicators

Section IV
Referenced Forms

DA Form 4106
Quality Assurance/Risk Management Document

Appendix B

CALENDAR OF QM/UM REVIEW & EVALUATION REPORTS TO MEDDAC QM/UM COMMITTEE

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
MEDICAL STAFF	X	X	X	X	X	X	X	X	X	X	X	X
DATA QUALITY WORKING GROUP	X	X	X	X	X	X	X	X	X	X	X	X
SURGERY	X	X	X	X	X	X	X	X	X	X	X	X
QM/UM	X	X	X	X	X	X	X	X	X	X	X	X
DCA		X			X			X			X	
ENVIRONMENT OF CARE (SAFETY)		X			X			X			X	
PRIMARY CARE QM		X			X			X			X	
PHARMACY	X			X			X			X		
LABORATORY SERVICE	X			X			X			X		
RADIOLOGY		X			X			X			X	
SWS		X			X			X			X	
DCMH/ PSYCHIATRY	X			X			X			X		
MERT		X			X			X			X	
PAD		X			X			X			X	
STANDARDS REVIEW COMMITTEE		X			X			X			X	
INFECTION CONTROL			X			X			X			X
NUTRITION			X						X			
PREVENTIVE MEDICINE			X						X			
OPTOMETRY	X			X			X			X		

(Revised 2 Feb 01)

Annual Indicator Use Planning Guide

Department/Service _____ Calendar Year

#	Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1													
	Status:												
2													
	Status:												
3													
	Status:												
4													
	Status:												
5													
	Status:												

MEDDAC Reg 702-1

Munson Army Health Center
Fort Leavenworth, Kansas 66027

Date of Report: _____

SUMMARY OF QUALITY IMPROVEMENT INDICATOR

Problem/Concern:

Goal/Indicator:

Service/Department: **Indicator Number:**

Date Identified: **Who/How Identified:** **Patient Population:**

Plan/Assessment/Recommendations:

Do/Action/Status:

Outcome/Measured effectiveness of Action Taken:

_____ Close _____ Continue to work _____ Other

Appendix D
(Signature Page Format)

(Office Symbol) (15-1a) **(Date of Meeting)**

Subject: Minutes of the **(month) (name of department/service)** Committee Meeting

1. The **(name of the department/service)** Committee was convened at **(time)**, on **(date)** in the **(location)** by **(chairperson)**.

2. Attendance. See enclosure 1.

3. Minutes Review. Minutes of **(date)** meeting were reviewed, and approved as written **(or with corrections noted)**.

4. **Old Business**. See enclosure 2.

5. **Monitoring and Evaluation Indicators**. See enclosure 3 (Annual Indicator Use Planning Guide & Summary of Quality Improvement Indicator forms.

6. New Business. See enclosure 4.

7. The meeting was adjourned at **(time)**. The next meeting is scheduled for **(time)**, **(date)** in the **(location)**.

(SIGNATURE BLOCK OF RECORDER)
Recorder

(SIGNATURE BLOCK OF CHAIRPERSON)
(Rank, Corps)
(Duty Position)

(Signature block of Reviewer)
(Rank, Corps)
(Duty Position)

Encls
1. Attendance Roster
2. Old Business
3. Monitoring and evaluation Indicators
4. New Business
5. (Any additional enclosures)

DISTRIBUTION
2 cy - QM/RM Coordinator (original + copy)
1 cy - Each committee member
1 cy - Reviewing (CAPSTONE) Committee

1 cy - Committee(s) to which recommendation(s) made

(Office Symbol) (15-1a)
SUBJECT: Minutes of the (***month***) (***name of department/service***) Committee Meeting

(Attendance Enclosure Format)

ATTENDANCE ROSTER
(year)

(Name of department/service) COMMITTEE MEETINGS

COMMITTEE MEMBER/REPRESENTATIVE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Title (Chairperson)/Department **Name**	X	X	C	X	X							
Title/Department **Name**	X	AL	X	X	X							
Title/Department **Name**	X	X	X	X	TDY							
Title/Department **Name**	X	X	X	S	X							
Chief, Dept. of Surgery Dr. A	X	X										
Chief, Dept. of Surgery Dr. B			X	X	X							
OTHERS												

X - MEMBER OR REPRESENTATIVE PRESENT
E - EXCUSED
C - CLINIC
AL - ANNUAL LEAVE
T - TDY
S - SICK LEAVE

(Old Business Enclosure Format)

OLD BUSINESS

Sample

Office Symbol) (15-1a)
SUBJECT: Minutes of the (***month***) (***name of department/service***) Committee Meeting

(Old Business Enclosure Format)

OLD BUSINESS

TOPIC	DISCUSSION FINDINGS	CONCLUSION RECOMMENDATION	ACTION FOLLOW UP EVALUATION
1. Issue Topic	Brief committee discussion and data presented.	Committee conclusion/recommendation.	Designation of action. Follow-up:
2. Issue Topic	Brief committee discussion and data presented.	Committee conclusion/recommendation.	Continue to monitor. Follow up:
3. Issue Topic	Brief committee discussion and data presented.	Committee conclusion/recommendation.	Closed.
4. Issue Topic			

(New Business enclosure Format)

NEW BUSINESS

SAMPLE

Office Symbol) (15-1a)
SUBJECT: Minutes of the (***month***) (***name of department/service***) Committee Meeting

(New Business Enclosure Format)

NEW BUSINESS

TOPIC	DISCUSSION FINDINGS	CONCLUSION RECOMMENDATION	ACTION FOLLOW UP EVALUATION
1. QM Indicators	Brief committee discussion and data presented.	Committee conclusion/recommendation.	Designation of action. Follow-up:
1. Blood Usage (if applicable)	Brief committee discussion and data presented.	Committee conclusion/recommendation.	Designation of action. Follow-up:
2. Drug Usage (if applicable)	Brief committee discussion and data presented.	Committee conclusion/recommendation.	Continue to monitor. Follow up:
3. Invasive Procedures (if applicable)	Brief committee discussion and data presented	Committee conclusion/recommendation.	Closed.
4. Risk Management (if applicable)			

Glossary

Section I
Abbreviations

AR
Army Regulation

BAMC
Brooke Army Medical Center

IAW
In Accordance With

MEDCEN
United States Army Medical Center

MEDCOM
United States Army Medical Command

MEDDAC
Medical Department Activity

MOU
Memorandum of Understanding

MTF
Medical Treatment Facility

USC
United States Code

USDB
United States Disciplinary Barracks

Section II
Terms

This section contains no entries.

Section III
Special Abbreviations and Terms

ACOE
Army Community of Excellence

AFAP
Army Family Action Plan

CQI(P)
Continuous Quality Improvement (Plan)

CWIE
Community-Wide Information Exchange

D&C
Dilatation & Curettage

DCCS
Deputy Commander for Clinical Services

GPRMC
Great Plains Regional Medical Center

HA
Health Affairs

I&D
Incision & Drainage

ICU
Intensive Care Unit

JCAHO
Joint Commission on Accreditation of Healthcare Organization

MAHC
Munson Army Health Center

MERTS
Munson Education, Readiness, Training, and Security

PAT

Process Action Team

PI(P)
Performance Improvement (Plan)

QI(P)
Quality Improvement (Plan)

QM/UM
Quality Management/Utilization Management

RM
Risk Management

RMC
Regional Medical Center

RCA
Root Cause Analysis

SE
Sentinel Event

SERT
Sentinel Event Response Team